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Chief Executive Officer

February 1, 2010

To: Supervisor Gloria Molina, Chair
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From: William T Fujioka
Chief Executive Officer

REPORT ON FIRST YEAR IMPLEMENTATION EVALUATION OF THE KATIE A. STRATEGIC PLAN ADOPTED BY THE BOARD OF SUPERVISORS ON OCTOBER 14, 2008

On October 14, 2008, your Board approved the Katie A. Strategic Plan, a single comprehensive and overarching vision of the current and planned delivery of mental health services to children under the supervision and care of child welfare. The Strategic Plan provides a single roadmap for the Countywide implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement, to be accomplished over a five-year period.

An implementation evaluation of the Enhanced Specialized Foster Care Plan (Plan) - the first Katie A. Plan developed to address the requirements of the Settlement Agreement - was conducted by Health Management Associates (HMA) in June 2007. The HMA critique cited several key issues impeding successful implementation, including:

- The lack of a clearly articulated vision of the desired "system of care" for foster children with mental health needs, accompanied by policies and procedures to guide implementation;

- Lack of training specific to the system of care; and

- Lack of data to demonstrate that critical elements of the Plan have been achieved, including completion of mental health screening for all detained children, completion of mental health assessments for all children with a positive mental health screening, and linkage and receipt of necessary mental health services for children with an assessed need for services.

The Strategic Plan is focused on addressing these barriers to successful implementation through the creation of enhanced staffing structures/teaming practices, joint Departments of Children and Family Services (DCFS)/Mental Health (DMH) policy directives, and joint training sessions to disseminate the primary components of the Strategic Plan and expectations for implementation. That said, improvements to the screening, referral, assessment, and linkage to children's mental health services continue to evolve and be refined over time as we learn to enhance operational effectiveness.

The Chief Executive Office (CEO), DCFS, and DMH committed to conduct an assessment in January 2010 to evaluate the first year Strategic Plan implementation rollout, Plan financing, and status of efforts to maximize revenue reimbursement. A consultant was contracted to conduct a series of focus groups and interviews through November and December 2009 in Service Planning Areas (SPAs) 1, 6, and 7 to determine the effectiveness of the Katie A. Strategic Plan and related Coordinated Services Action Team (CSAT) rollout and implementation in the Phase I offices (Attachment I).

A total of 27 focus groups at seven DCFS offices were conducted across the three SPAs, which included four participant groups: 1) Children's Social Workers (CSWs); 2) Supervising Children's Social Workers (SCSWs); 3) DMH co-located Specialized Foster Care staff/supervisors; and 4) DCFS CSAT staff, inclusive of the CSAT lead per area office, Service Linkage Specialist (SLS), Multidisciplinary Assessment Team (MAT) Coordinators, Wraparound Liaisons, D-Rate Evaluators, Public Health Nurses (PHNs), educational liaisons, Youth Development Specialists, Permanency Partners Program (P3) staff, Adoption Safe Families Act staff, Linkages co-located staff, Resource Utilization Management (RUM)/Resource Utilization Management Process (RMP) staff, and Team Decision Making (TDM) Facilitators. The data collection process also included 23 individual interviews with DCFS Regional Administrators/Assistant Regional Administrators and DMH District Chiefs/Program Heads.

The focus groups examined the following topical areas:

- Mental Health Screenings: To what extent and in what manner were children in child welfare being screened for mental health needs?

- Referrals to Assessments for Children with Positive Mental Health Screenings: To what extent and in what manner are children in foster care with a positive mental health screening being referred to an assessment?

- Assessments for Children with Positive Mental Health Screenings and Linkage to Mental Health Services: To what extent and in what manner are children with a positive mental health screening being assessed and linked to mental health services?

- Mental Health Service Provision: To what extent and in what manner are mental health services being provided to children with mental health needs?

Executive Summary: Highlights from Implementation Evaluation

The evaluation project found that the screening and referral processes were the components most successfully implemented in this initial phase. By contrast, the assessment and service linkage processes encountered the greatest challenges. Service provision also faced numerous challenges, but the implementation of this component was too recent in two of the three SPAs to gauge its key strengths and challenges.

The following sums up the specific strengths and challenges of implementing the four components:

1. Mental Health Screening Process

   Strengths: The process put in place to screen for the mental health needs of children in the child welfare system seems robust across the seven sites. The implementation included seven elements that comprise a "system"': (a) an easy-to-use screening tool for mental health needs; (b) practical training on how to administer the screening tool; (c) ongoing formal and informal support on how to fill out the screening tool; (d) explicit protocols and roles specifying who is responsible for filling out the screening tool; (e) multiple checkpoints to ensure that all children have a completed screening tool on file; (f) a data-tracking system that alerts staff members to the status of the child; and (g) cross-system ownership over the early identification of mental health needs.

   Key challenges: Ensuring that all children with existing cases are screened for mental health needs, and administering the mental health screening tool consistently across different, complex, and time-limited situations, including the medical Hubs.

2. Referrals to Assessments

Strengths: The process of referring children with positive mental health screenings to assessments also appears to be strong and functioning as a 'system'. Offices have formal procedures for referring cases, clear roles and responsibilities, a checklist of what constitutes a completed referral packet, and a data-tracking system to keep the case moving toward an assessment. The coordinators of MAT and the SLS play instrumental roles in ensuring that the 'packets' required to conduct an assessment are prepared quickly and fully: they participate in TDM sessions with relevant stakeholders early in the process to focus on the newly detained, non-detained, or existing case; and they are also authorized to access the MedsLite system to accelerate the determination of Medi-Cal eligibility for children.

Key challenges: Obtaining the necessary consent for services in a timely fashion, and determining, obtaining and maintaining benefits for certain children in the child welfare system that are eligible for Medi-Cal.

3. Assessment and Linkage Activities

Strengths: The CSAT is viewed as a structure that has brought greater order, efficiency, and accountability to assessment and linkage services for newly detained cases (Track 1) and non-detained and existing cases (Tracks 2 and 3, respectively). CSWs underscored that CSAT brings together staff with special skills, knowledge, resources and networks to ensure that children who are newly detained, non-detained or with existing cases are appropriately and efficiently assessed and linked to services.

However, in contrast to screening and referral processes, staff members reported encountering a greater number of implementation challenges with assessment and linkage activities.

Key challenges: Varied by track and SPA:

- Track 1 (Newly Detained Cases): Availability of Assessment Slots and Assessment Capacity Issues: In some SPAs, as the providers began to ramp up their staffing to perform MAT assessments, the number of newly detained children needing assessments exceeded the amount of MAT spaces available for assessments; and in some instances, MAT providers responsible for coordinating assessments and linkage lacked the linguistic, cultural, or other capacities to conduct assessments. These issues were particularly present in SPA 1.

- Track 1 (Newly Detained Cases): Difficult Deadlines, Expectations, and Additional Costs: Staff involved with Track 1 cases reported conflicting or unrealistic deadlines for completing the assessments, chronic delays with reports essential to completing the assessments (especially medical Hub reports), inconsistent expectations for completing an assessment (especially the Summary Findings Report), and the inability to cover the full costs of assessment and linkage services.

- Track 2 and 3 (Non-Detained and Existing Cases): Distancing, Roles, and Partnerships: Case-carrying CSWs involved with non-detained and existing cases reported feeling increasingly distanced from the case and the mental health service providers as the case moved through the assessment and linkage process facilitated by the SLS and DMH Co-located staff; Co-located staff stressed feeling that their roles in linking children to services have expanded beyond their skill sets; and Co-located staff also indicated that the collaboration with DCFS has not been entirely conducted as an equal partnership, thus impacting DMH Co-located staff morale.

4. Mental Health Service Provision[1]

Strengths: All offices expressed confidence that Wraparound services provided mental health services in accordance with the practice principles specified in the Strategic Plan. CSWs and Intensive Social Workers (ISWs) reported that they regularly check in with Wraparound service providers regarding case files.

Key challenges: Centered on non-Wraparound services.

- First, CSWs revealed a lack of clarity concerning their role(s) in Child/Family Teams specified in the Strategic Plan. (It should be noted that the Core Practice Model training curriculum, which will articulate teaming and family engagement expectations and practices for DCFS, DMH, and contracted mental health providers, is still being developed and has not been implemented yet.)

[1]Line staff reported having less experience with mental health service provision. In large part, this is due to the fact that two of the three SPAs had only just begun implementing the Strategic Plan. Moreover, mental health providers were not part of the focus groups or interviews. Most information about mental health service provision came from CSWs and DMH Co-located staff focus groups, supplemented by a special meeting of the Children's Mental Health Providers Network held on December 2, 2009.

- Second, CSWs cited the lack of strong mechanisms for cross-agency collaboration that integrate them into service provision teaming structures. CSWs indicated that most of the communication between them and mental health providers tends to revolve around court-mandated reports or file updates and that these reports do not typically contain qualitative information that would help determine case outcomes. CSWs cited confidentiality regulations as a barrier to accessing more in-depth qualitative information beyond what is court-mandated.

- Third, mental health service providers felt confident in being able to implement services using the practice principles stipulated in the Strategic Plan (for example, Core Practice Model, Trauma Informed Practices, and Intensive Home-Based Services). However, they stressed three structural constraints that affect their capacity to implement mental health services in accordance with the practice principles: the inability to bill fully for the array of services; the costs of training staff members in the practice principles (especially if universities are not training new professionals in these practice skills); and a perception that department managers lack clear buy-in and a set of expectations about the practice principles.

RECOMMENDATIONS

The recommendations, presented herein, respond to the implementation challenges identified by staff with the screening, referral, assessment and linkage, and service provision activities. These recommendations are presented in the form of goals, rather than specific strategies. The development of specific strategies to address these recommendations, as well as the planning structures needed to arrive at those solutions (for example, committees, timelines, etc.), is outside the scope of this evaluation project and will require bringing together people with the relevant knowledge, authority, and skills to generate specific solutions to the reported challenges.

Screening Process

1. Further formalize the roles of staff that are responsible for ensuring that in existing cases, children are screened for mental health needs.

2. Improve the process of filling out the mental health screening tool in specific contexts, namely for children 0-5 years of age, for crisis situations and in the medical Hubs.

Referrals to Assessments

1. Improve the ways in which release of information and consent for mental health treatment are obtained.

2. Minimize the problems of Medi-Cal enrollment and disenrollment, particularly for children with private insurance, HMO Medi-Cal, or placements outside Los Angeles County.

Assessment and Service Linkage

1. Align the various deadlines for completing assessments.

2. Reduce delays of reports from the medical Hubs.

3. For Newly Detained Cases:

    a. Consider establishing a system to redistribute MAT slots across SPAs;

    b. Increase MAT provider capacity for conducting assessments in specific SPAs;

    c. Strengthen the protocols (roles, expectations, and processes) for completing the Summary of Findings Report; and

    d. Address the billing issues reported by MAT providers regarding covering the full costs of assessments and service linkage.

4. For Non-Detained and Existing Cases:

    a. Clarify the role of DMH Co-located staff and mental health providers with regard to assessments and service linkage activities; and

    b. Address partnership issues between DCFS and DMH staff to support and foster a better collaborative relationship.

Mental Health Service Provision

1. Increase the understanding of CSWs regarding their role in Child/Family Teams.

2. Strengthen the relationship between CSWs and mental health providers by reducing communication barriers and creating mechanisms to gauge quality of services and outcomes.

3. Address the structural constraints reported by mental health providers that affect their capacity to implement mental health services in accordance with the practice principles stipulated in the Strategic Plan.

Plan Financing and Status of Efforts to Maximize Revenue Reimbursement

Budget Status

The projected full-year cost for the Fiscal Year (FY) 2009-10 Katie A. Budget is $151,746,000 comprised of $84,742,000 in Federal/State revenue and $67,004,000 in Net County Cost (NCC). Currently, it is estimated that there is approximately $8.4 million in NCC savings for FY 2009-10. However, this figure may decline due to several priority initiatives identified in 2009 (i.e., MacArthur Foundation leveraged Child System Treatment and Enhancement Project, SAS Dataflux software, Trauma-Focused Cognitive Behavioral Therapy training, and one-time renovation/equipment related expenses at two Medical Hubs) after the development of the Katie A. Strategic Plan and corresponding budget. Funding for these initiatives was directed to be offset by use of the current year FY allocation for Katie A. This coupled with intensified efforts to boost referrals to Tier II Wraparound, which rolled out in the summer of 2009, should reduce FY 2009-10 savings. A better estimate of current year expenditures and savings will be available in March 2010 at the next Katie A. Quarterly Status Update to the Board.

Efforts to Maximize Revenue Reimbursement

The CEO, County Counsel, and DMH continue to work very closely together to try to maximize revenue reimbursement to the County. Efforts are focused on participation in the negotiations between the Special Master, Rick Saletta, and Plaintiffs'/Defendants' counsel in the State portion of the Katie A. case, in addition to requesting frequent status updates on California's Medi-Cal State Plan Amendment (SPA), which is discussed in more detail below. Currently, Medi-Cal pays for Wraparound services under the Medi-Cal Schedule of Maximum Allowances (SMA). The current SMA does not adequately account for necessary administrative activities (i.e., scheduling meetings, copying materials, document review, etc.) when providing mental health services in a Wraparound setting.

Mediations between the Plaintiffs and the State began in June 2009. In mid-June, the County submitted a letter to Mr. Saletta, which was a follow-up to a County declaration submitted at the request of the Federal Court. The letter to Mr. Saletta provides the County's suggested clarifications to a State DMH All County Letter issued in October 2008, regarding Medi-Cal billing for specialty Mental Health Services, such as Wraparound, provided to children in foster care. The letter provided detailed analyses of where the State has defined reimbursable Medi-Cal activities in an unduly narrow fashion, and further recommends that the State formally adopt the Early Periodic Screening Diagnosis and Treatment (EPSDT) Chart Documentation Manual as the official authority on acceptable standards for documenting EPSDT services (Attachment II). If the State were to adopt the positions taken in the letter, providers of Wraparound services could obtain higher reimbursement without concern about facing repayment obligations on audit.

The meetings between the Special Master, County DMH, Plaintiffs, and State have been occurring weekly since the beginning of the summer. There was a break in the negotiations over the December holidays and the meetings just recently resumed on January 21, 2010. The parties traveled to Los Angeles to have a broader discussion with County representatives regarding the management and funding of Wraparound - related services and the structures/mechanisms that the County has developed for screening, referring, and linking children in the foster care system to mental health services. The mediations led by the Special Master have focused on the following topics:

- Service array and practice development: descriptions of coordinated, comprehensive, community-based services, including access, planning, delivery, and transition;

- System structure and fiscal options: the structure and fiscal system which supports the practices and services model; and

- Quality improvement and education: the standards and methods to achieve quality-based oversight, and develop training and education that support the practice and fiscal models.

The intent of the discussions is to identify the areas of consensus/divergence among the parties and to determine if any compromises can be made regarding the reimbursement of the nine components of Wraparound that the Plaintiffs' attorneys advocate should be Medi-Cal reimbursable service activities. Participants in the negotiations, including our County representatives, have signed confidentiality agreements. It is our understanding, that this phase of the negotiations is drawing to a

close. The Special Master is tentatively scheduled to issue a report to the Court by March 2010, discussing the progress made between the parties and his recommended next steps.

In early October 2009, the County had a conference call with John O'Brien, a Medicaid expert from the Technical Assistance Collaborative that provided expertise to the State of Massachusetts in the Rosie D. lawsuit. Similar to Katie A., the Plaintiffs in Massachusetts filed a civil action against the state based on the lack of medically necessary mental health services which could avert the risk of prolonged or unnecessary hospitalizations or out-of-home placements for thousands of Medicaid eligible children. The Federal Court in Rosie D. ordered Massachusetts to make a number of improvements in relation to the provision of Medicaid-funded EPSDT services, most notably, to provide EPSDT services within a Wraparound-like continuum of care to children with serious emotional disturbance. What we learned from this call is that Massachusetts identified Wrap-related services as a process and not a service activity within their SPA. They created broad service categories (mobile crisis intervention and crisis stabilization; in-home behavioral supports; in-home therapy services; mentoring; and parent/caregiver supports) similar to those advocated by the Plaintiffs in the State Katie A. case. However, as the County has understood, the Massachusetts program focuses on the child's mental health issues, and family services are seen only as an adjunct to such care. Moreover, Federal funding for these services is ultimately subject to the approval of the Centers for Medicare and Medicaid Services (CMS). Some service modalities, such as rehabilitation, have been difficult to define in Massachusetts and have led to ongoing discussions with CMS. The State of Massachusetts has developed operational definitions and detailed service manuals to define coverable service components. This is something that would greatly benefit California and is what the County's June 2009 letter to the Special Master recommended.

According to Mr. O'Brien, the good news is that the climate at CMS is changing for the better; once officials within CMS are educated on the nuances of a service activity, they are generally reasonable. Mr. O'Brien has not seen any state attempt to bundle service activities, which is something the County is interested in. However, it could be a possibility in the future now that there is new leadership at CMS. The bottom line is any change to California's State Plan will take time and there is no silver bullet to address all of the funding issues surrounding the provision of Wraparound services.

The County has communicated with the State on a couple of occasions over the last six months to discuss increasing the SMA rates; the most recent communication was on January 12, 2010. Thus far, the State has been non-responsive to the County's inquiries. If the State is not interested in setting new rates for the SMA, the County's

hands are tied as this issue cannot be broached directly with CMS as the County does not have authority to negotiate directly with CMS. Should that occur, the County would need to seek a legislative approach where the legislature would require the State to set the rate by statute. This, of course, would be much harder to achieve as an increase in SMA would require an additional state general fund contribution.

The proposed mental health services SPA would permit the County to draw down federal matching funds for amounts paid which are above the SMA, and would therefore provide some relief even if the SMA were not increased. From what we understand, the mental health services SPA submitted to CMS in March 2009 has generated complicated requests for additional information (RAIs), from CMS, which are focused on various coverage issues. This process could drag on for months, particularly given the State furloughs. The SPA can be approved retroactively, but will not be effective until the State and CMS resolve the multitude of coverage issues that CMS raised over the summer. Therefore, the County's most viable opportunity to maximize revenue reimbursement for specialty mental health services, such as those provided via Wraparound and which are the costliest service components within the Strategic Plan, is through continued participation in the Special Master mediated negotiations between the Plaintiffs and State. At the January 21, 2010 meeting, the County committed to putting together a list of fiscal, programmatic, legal, and regulatory/administrative barriers effecting the implementation of the Strategic Plan. We will continue to keep you apprised of any progress in these discussions and will continue to inquire with the State the status of the SPA and opportunities for maximizing the SMA.

Summary

A review of first year implementation efforts signify the substantive achievements that occurred in 2009 in implementing the Strategic Plan, as well as the challenges and ongoing work that lies ahead to refine mental health screening, referral, assessment, and service linkage processes for foster children. The CSAT staffing structure implemented in SPAs 7, 6, and 1 and scheduled for Countywide rollout in 2010 was primarily developed to address the deficiencies cited in the HMA report. The fundamental critique identified by HMA that drove the development of the Strategic Plan was the lack of a coordinated vision and model of care guiding systematic processes for mental health screening, assessment, and the provision of timely and appropriate mental health services for children in child welfare.

As articulated in the Executive Summary of the Implementation Evaluation, issues concerning consent for information/treatment, Medi-Cal enrollment/billing issues, competing assessment priorities/deadlines, report delays, service slot shortages, and

inter-departmental tensions are generally known to Project Managers on Katie A. For several of these, corrective actions to improve overall functioning are already underway, and as a result of this report others will be developed. As our knowledge for developing, implementing and refining mental health screening, assessment, and service provisions has evolved, so has the list of obstacles to tackle. We will continually strive to seek solutions to the obstacles impeding our progress. The next Quarterly Status Report will be submitted on March 31, 2010.

If you have any questions, please let me know or your staff may contact Jacqueline White, Deputy Chief Executive Officer at (213) 974-4530 or via e-mail at jwhite@ceo.lacounty.gov.

WTF:JW:SS
KH:LB:yw

Attachments (2)

c: Executive Office, Board of Supervisors
County Counsel
Department of Children and Family Services
Department of Mental Health

Attachment I

Implementation Evaluation Report

Phase One Implementation: *Katie A. Strategic Plan*

Prepared for the County of Los Angeles

Chief Executive Office

Department of Children and Family Services

Department of Mental Health

January 2010

The *INNOVA* Group, Inc.

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Acknowledgements

The *INNOVA* Group, Inc., would like to thank the staff of the Los Angeles County Department of Children and Family Services, Department of Mental Health, and Chief Executive Office who provided guidance with different aspects of this evaluation project and who participated in interviews and focus groups, sharing their experiences and insights on how to improve mental health screening and assessment and mental health service provision for children and youth in the child welfare system in Los Angeles County.

The *INNOVA* Group, Inc., would also like to thank its partners and assistants who helped gather and analyze the information for this evaluation project.

Rigoberto Rodriguez, Ph.D.
The *INNOVA* Group, Inc.
January 2010

I.EXECUTIVE SUMMARY

A. Background

On October 14, 2008, the Los Angeles County Board of Supervisors approved the Katie A. Strategic Plan containing 'a single comprehensive vision for the current and planned delivery of mental health services to children under the supervision and care of child welfare, as well as for those at-risk of entering the child welfare system.'[1] The Strategic Plan seeks to fulfill the objectives identified in the Katie A. Settlement Agreement[2] in two phases over a five-year period. The first phase would be implemented in three Service Planning Areas (SPA): SPA 7 (Santa Fe Springs and Belvedere) started in May 2009; SPA 6 (Compton, Vermont, Waterridge) began in August 2009; and SPA 1 (Palmdale and Lancaster) started in September 2009. The second phase is slated to begin in early 2010 covering SPAs 2, 3, 4, 5 and 8. The Strategic Plan also stipulated that an assessment be conducted of the initial implementation activities to inform the roll out of the plan in the remaining parts of the County.

This evaluation report summarizes the key strengths and challenges in the implementation of two specific components of the Strategic Plan—mental health screening and assessment, and mental health service provision—and it offers recommendations to improve phase two of the implementation. The strengths, challenges, and recommendations identified in this evaluation report stem from information collected in November and early December 2009 about the experiences of line staff and managers from the Department of Children and Family Services (DCFS), the Department of Mental Health (DMH), and Children's Mental Health Providers responsible for conducting mental health screenings, referrals, assessments, and linkages, as well as providing mental health services to children in the child welfare system.

The evaluation project explored four specific components regarding mental health screenings, assessments, and service provision:

1. Mental Health Screenings: What were the strengths and challenges in the efforts to screen all children for mental health needs? How can these efforts be improved?

[1] County of Los Angeles Department of Children and Family Services and Department of Mental Health, Katie A. Strategic Plan, October 2, 2008.

[2] Katie A., et al. v. Diana Bontá, et al. (2003).

2. Referrals to Assessments for Children with Positive Mental Health Screenings: What were the strengths and challenges in the efforts to refer children with a positive mental health screening for an assessment? How can these efforts be improved?

3. Assessments for Children with Positive Mental Health Screenings and Linkage to Mental Health Services: What were the strengths and challenges in the efforts to assess children with a positive mental health screening and to link them to services? How can these efforts be improved?

4. Mental Health Service Provision: What were the strengths and challenges in the efforts to provide mental health services (in accordance with the practice principles stipulated in the Strategic Plan)? How can these efforts be improved?

B. Key Findings

The evaluation project found that the screening and referral processes were the components most successfully implemented in this initial phase. By contrast, the assessment and service linkage processes encountered the greatest challenges. Service provision also faced numerous challenges, but the implementation of this component was too recent in two of the three SPAs to gauge its key strengths and challenges.

The following sums up the specific strengths and challenges of implementing the four components:

1. Mental Health Screening Process

   Strengths: The process put in place to screen for the mental health needs of children in the child welfare system seems robust across the seven sites. The implementation included seven elements that comprise a 'system': (a) an easy-to-use screening tool for mental health needs; (b) practical training on how to administer the screening tool; (c) ongoing formal and informal support on how to fill out the screening tool; (d) explicit protocols and roles specifying who is responsible for filling out the screening tool; (e) multiple checkpoints to ensure that all children have a completed screening tool on file; (f) a data-tracking system that alerts staff members to the status of the child; and (g) cross-system ownership over the early identification of mental health needs.

   The key challenges with the screening process are two: ensuring that all children with existing cases are screened for mental health needs, and administering the mental health screening tool consistently across different and complex, time-limited situations, including the medical Hubs.

2. Referrals to Assessments

Strengths: The process of referring children with positive mental health screenings to assessments also appears to be strong and functioning as a 'system.' Offices have formal procedures for referring cases, clear roles and responsibilities, a checklist of what constitutes a completed referral packet, and a data-tracking system to keep the case moving toward an assessment. The coordinators of the Multidisciplinary Assessment Teams (MAT) and the Service Linkage Specialists (SLS) play instrumental roles in ensuring that the 'packets' required to conduct an assessment are prepared quickly and fully: they participate in Team Decision Making (TDMs) sessions with relevant stakeholders early in the process to focus on the newly detained, non-detained, or existing case; and they are also authorized to access the MedsLite system to accelerate the determination of Medi-Cal eligibility for children.

The key challenges with referring children to assessments are two: obtaining the necessary consent for services in a timely fashion, and determining, obtaining and maintaining benefits for certain children in the child welfare system that are eligible for Medi-Cal.

3. Assessment and Linkage Activities:

Strengths: The Coordinated Service Action Team (CSAT) is viewed as a structure that has brought greater order, efficiency, and accountability to assessment and linkage services for newly detained cases (Track 1) and non-detained and existing cases (Tracks 2 and 3, respectively). CSWs underscored that CSAT brings together staff with special skills, knowledge, resources and networks to ensure that children who are newly detained, non-detained or with existing cases, are appropriately and efficiently assessed and linked to services.

However, in contrast to screening and referral processes, staff members reported encountering a greater number of implementation challenges with assessment and linkage activities.

The key challenges for assessing and linking children to services varied by track and Service Planning Area.

- Track 1 (Newly Detained Cases): Availability of Assessment Slots and Assessment Capacity Issues: In some SPAs, as the providers began to ramp up their staffing to perform MAT assessments, the number of newly detained children needing assessments exceeded the amount of Multidisciplinary Assessment Team spaces

available for assessments; and in some instances, MAT providers responsible for coordinating assessments and linkage lacked the linguistic, cultural, or other capacities to conduct assessments. These issues were particularly present in SPA 1.

- Track 1 (Newly Detained Cases): Difficult Deadlines, Expectations, and Additional Costs: Staff involved with Track 1 cases reported conflicting or unrealistic deadlines for completing the assessments, chronic delays with reports essential to completing the assessments (especially medical Hub reports), inconsistent expectations for completing an assessment (especially the Summary Findings Report), and the inability to cover the full costs of assessment and linkage services.

- Track 2 and 3 (Non-Detained and Existing Cases): Distancing, Roles, and Partnerships: Case-carrying Children's Social Workers (CSWs) involved with non-detained and existing cases reported feeling increasingly distanced from the case and the mental health service providers as the case moved through the assessment and linkage process facilitated by Service Linkage Specialist (SLS) and DMH Co-located staff; Co-located staff stressed feeling that their roles in linking children to services have expanded beyond their skill sets; and Col-located staff also indicated that the collaboration with DCFS has not been entirely conducted as an equal partnership, thus impacting DMH Co-located staff morale.

4. Mental Health Service Provision[3]:

Strengths: All offices expressed confidence that Wraparound services provided mental health services in accordance with the practice principles specified in the Strategic Plan. CSWs and Intensive Social Workers (ISWs) reported that they regularly check in with Wraparound service providers regarding case files.

The three key challenges with mental health service provision centered on non-Wraparound services.

- First, CSWs revealed a lack of clarity concerning their role(s) in Child/Family Teams specified in the Strategic Plan. (It should be noted that the Core Practice Model training curriculum, which will articulate teaming and family engagement

[3] Line staff reported having less experience with mental health service provision. In large part, this is due to the fact that for two of the three SPAs had only just begun implementing the Strategic Plan. Moreover, mental health providers were not part of the focus groups or interviews. Most information about mental health service provision came from CSWs and DMH Co-located staff focus groups, supplemented by a special meeting of the Children's Mental Health Providers Network held on December 2, 2009.

expectations and practices for DCFS, DMH, and contracted mental health providers, is still being developed and has not been implemented yet.)

- Second, CSWs cited the lack of strong mechanisms for cross-agency collaboration that integrate them into service provision teaming structures. CSWs indicated that most of the communication between them and mental health providers tends to revolve around court-mandated reports or file updates and that these reports do not typically contain qualitative information that would help determine case outcomes. CSWs cited confidentiality regulations as a barrier to accessing more in-depth qualitative information beyond what is court-mandated.

- Thirdly, mental health service providers felt confident in being able to implement services using the practice principles stipulated in the Strategic Plan (for example, Core Practice Model, Trauma Informed Practices, and Intensive Home-Based Services). However, they stressed three structural constraints that affect their capacity to implement mental health services in accordance with the practice principles: the inability to bill fully for the array of services; the costs of training staff members in the practice principles (especially if universities are not training new professionals in these practice skills); and a perception that department managers lack clear buy-in and a set of expectations about the practice principles.

C. RECOMMENDATIONS

These recommendations respond to the implementation challenges identified by staff with the screening, referral, assessment and linkage, and service provision activities. These recommendations are presented in the form of goals, rather than specific strategies. The development of specific strategies to address these recommendations, as well as the planning structures needed to arrive at those solutions (for example, committees, timelines, etc.), is outside the scope of this evaluation project and will require bringing together people with the relevant knowledge, authority, and skills to generate specific solutions to the reported challenges.

Screening Process

1. Further formalize the roles of staff who responsible for ensuring that in existing cases children are screened for mental health needs.

2. Improve the process of filling out the mental health screening tool in specific contexts, namely for children 0-5, for crisis situations, and in the medical Hubs.

Referrals to Assessments

1. Improve the ways in which release of information and consent for mental health treatment are obtained.

2. Minimize the problems of Medi-Cal enrollment and disenrollment, particularly for children with private insurance, HMO Medi-Cal, or placements outside Los Angeles County.

Assessment and Service Linkage

1. Align the various deadlines for completing assessments.

2. Reduce delays of reports from the medical Hubs.

3. For Newly Detained Cases:
   a. Consider establishing a system to redistribute MAT slots across SPAs.

   b. Increase MAT provider capacity for conducting assessments in specific SPAs.

   c. Strengthen the protocols (roles, expectations, processes) for completing the Summary of Findings Report.

   d. Address the billing issues reported by MAT providers regarding covering the full costs of assessments and service linkage.

4. For Non-Detained and Existing Cases:
   a. Clarify the role of DMH Co-located staff and mental health providers with regard to assessments and service linkage activities.

   b. Address partnership issues between DCFS and DMH staff to support and foster a better collaborative relationship.

Mental Health Service Provision

1. Increase the understanding of CSWs regarding their role in Child/Family Teams.

2. Strengthen the relationship between CSWs and mental health providers by reducing communication barriers and creating mechanisms to gauge quality of services and outcomes.

3. Address the structural constraints reported by mental health providers that affect their capacity to implement mental health services in accordance with the practice principles stipulated in the Strategic Plan.

D. Report Structure

The report contains five sections.

1. The first section describes the strengths, challenges and recommendations for the process of screening children for mental health needs.
2. The second section describes the strengths, challenges, and recommendations for the process of referring children to assessment and service linkage services.
3. The third section describes the strengths, challenges, and recommendations for the process of assessing and linking children with mental health needs to appropriate services.
4. The fourth section describes the strengths, challenges, and recommendations for mental health service provision.
5. The Appendices provide background information of the following:
    - the evaluation approach and methods, including the limitations of this report;
    - the Strategic Plan's six interlocking goals;
    - the mental health screening and assessment and mental health service provision strategies;
    - the questionnaire used to conduct focus groups and interview;
    - a glossary of terms used in this report; and
    - a reference list of the focus groups and interviews conducted.

II. IDENTIFYING CHILDREN WITH MENTAL HEALTH NEEDS

A. Summary

The activities for mental health screening of children in the County's child welfare system were implemented quite successfully during the first implementation phase.

The screening activities were implemented through a 'system' with seven elements: (a) an easy-to-use mental health screening tool (MHST) that was developed by the California Institute for Mental Health (CIMH); (b) practical training on how to administer the MHST; (c) ongoing formal and informal support on how to conduct the screening; (d) protocols specifying the roles and responsibilities of staff for administering the screening tool; (e) multiple checkpoints to ensure that all files contain a completed screening tool; (f) a data-tracking system to alert staff members to the status of a case; and (g) cross-system ownership of the early identification of mental health needs.

The screening process encountered two challenges. The first challenge is ensuring that all existing cases have been administered a mental health screening. The second challenge is filling out the screening tool consistently in complex and time-limited situations.

B. What Worked Well?

Focus group participants and interviewees felt confident that the screening process put in place to flag the possibility of mental health issues of children currently in or entering the child welfare system is quite strong. The following elements were cited:

<u>The mental health screening tool is simple and easy to use.</u>

- The straightforward, one-page MHST is relatively easy and quick to understand and administer.

- The simplicity of the MHST allows multiple staff to fill out the form completely.

<u>Staff members received training and formal and informal support after the training</u>.

- The MHST trainings were effective, helpful, and were delivered across all the sites to a broad range of staff members involved in screening. Focus groups felt that the mix of DCFS and DMH staff made for a positive environment. The use of hypothetical situations when practicing filling out the MHST allowed everyone to share their reasoning for filling the form out in a specific way, and therefore, participants learned from each other.

- Formal and informal support was provided for CSWs, ISWs and ER workers regarding how to administer the MHST. CSWs and Assistant Regional Administrators noted that after the initial trainings, mini-trainings were held for the DMH Co-located staff and DCFS staff to broaden their understanding of the MHST. DMH Co-located staff and DCFS staff members have continued this collaboration. Two offices have implemented monthly meetings involving CSWs, SLS, MAT Coordinators, and DMH Co-located staff. These meetings are used to answer any questions regarding the MHST, and address any issue that arises.

- A noticeable amount of informal support was also provided to CSWs. DMH Co-located staff members have been a source of information and assistance for CSWs and ISWs. This assistance was provided on a case-by-case basis and the level of assistance varied by site.

<u>All offices have procedures for administering the MHST</u>.

- Although there are some differences in procedures among offices, they generally follow a similar pattern. For new cases, the MHST is completed at the first point of contact, during the investigation and/or the medical screening. The first person responsible for completing the MHST varies by office, but generally this person is the ER worker, CSW, ISW or staff at the medical Hub.

- Existing cases are reviewed by the CSW or ISW at the time of an incident or at the next case plan update. The Regional Administrator and Assistant Regional Administrators have been responsible for selecting which staff will be responsible for completing the MHST and related documentation. There is flexibility in the policy for each office to establish certain protocols that best fit the needs of the office.

<u>There are multiple checkpoints in the system to verify that children have been screened for mental health needs.</u>

- For children entering the child welfare system, as newly detained or non-detained, there are numerous points where the MHST is reviewed for completion. For example, medical Hub staff complete the MHST for all newly detained children who go to a Medical Hub, then faxed to the regional office where it is reviewed by the CSW, SCSW, and SLS or MAT Coordinator. For all other children, the MHST is completed by the CSW, reviewed by the SCSW, and transferred to the SLS or MAT Coordinator to review, track, and take necessary follow-up action regarding service linkage. In addition, the MHST is often

completed at the TDM, so this provides another level of review and/or opportunity for input.

- If the mental health screening comes back negative at the point of entry into the child welfare system (i.e., newly detained or non-detained cases), a second opportunity to screen for the child's mental health needs exists at the time of the case plan update, if any behavioral indicator on the MHST is observed, or if there is an incident with the child.

- For children with existing cases who have not previously had an MHST screening, a review is conducted at the next case plan update or at a time of a behavioral indicator or incident. If the CSW does not conduct the screening at the six-month point, the SCSW/SLS functions as a checkpoint to ensure that every child has been screened for mental health needs.

The data tracking system keeps staff members connected and fosters accountability regarding mental health screenings.

- The data-tracking system helps keep staff connected concerning the mental health needs of children with positive screenings, allows for transmission of information and files from one point in the system to another, and allows multiple entities access to data about the children with positive screenings.

- For example, CSWs reported that the SLS is able to send them messages on the status of cases that are nearing specific deadlines. Communication is carried out via emails, phone calls, and in person. This combination of communication strategies allowed staff members to get the most accurate and updated information on the case, while providing an open line of communication on any issues that might delay sending the file to the SLS or MAT Coordinator. They indicated that this was very helpful in keeping track of deadlines and monitoring cases.

There is enhanced cross-system ownership of the identification of mental health needs of children in the child welfare system.

- ER workers, CSWs, and medical Hub workers reported having a greater awareness of the need to identify the mental health needs of children in the child welfare system. They indicated being more able now to identify symptoms more quickly upfront. The trainings have helped CSWs better explain to parents or caregivers about the various mental health services and ease any of their concerns. Many ER workers also revealed that a shift had occurred in their thinking, where a child's mental health needs was on par with ensuring the safety and welfare of the child and no longer an afterthought.

C. What Were the Challenges?

Ensuring that all existing cases have been administered a mental health screening.

- Staff members did not explicitly raise concerns that existing cases are not receiving mental health screenings. Rather, the evaluation team is raising this as a possible challenge based on two observations.

    - First, unlike the newly detained and non-detained cases entering the system, the existing cases have fewer checkpoints to catch if a mental health screening has not been conducted. Currently, as reported via the focus groups and interviews, if a CSW or ISW does not complete an MHST during an incident or at the six-month review point, the only person who would catch this omission is the SCSW.

      However, the SCSW focus groups consistently reported a spike in the workload during the first six months of implementing the screening activities, and indicated feeling overwhelmed with the amount of work because during the first six months all the cases are reviewed in accordance with the six-month case update policy. The workload on the shoulders of the SCSW during these six months can weaken their ability to ensure that all children who need an MHST administered actually have a completed MHST on file.

    - Second, the evaluation team understands that another staff member, the RTS, functions as a safeguard on this issue because the RTS can catch if a case has gone without an update and alert the CSW or SCSW. However, focus groups participants and interviewees did not mention that the RTS formally checks the file for the completion of a MHST. The evaluation team is raising this is as a concern just to be sure that such a role is formalized to strengthen this checkpoint to ensure that existing cases are administered a MHST.

Administering the MHST consistently under complex circumstances.

- Children 0-5: DCFS staff members reported being comfortable using the MHST with children over the age of five because symptoms seem clearer and the ability to speak with the child can help flag the possibility of mental health needs. However, staff indicated that identifying symptoms for children under five is more difficult, in part, because the symptoms may not be visible or the inability of children in that age group to express themselves, among other reasons. This situation has led some staff members to record 'unknown' in certain parts of the MHST. Although marking unknown is not in itself a problem, it automatically triggers a full assessment conducted via MAT or Co-located

staff. DMH Co-located staff members indicated that many of the children under five with 'unknown' on the MHST end up being false positives for mental health problems.

- Crisis Situations: ER workers reported having difficulty completing the MHST when they are working with a family and/or child in a crisis situation, such as cases of immediate removal (24-hour period) and five-day referrals. ER workers pointed out that a crisis will tend to affect a child's behavior in the short term (24-hour period or five-day referral), but their behavior may have substantially changed after this five-day period, that is to say, by the time the child is seen at the TDM or for a full assessment. ER workers noted that they do not typically have enough time to observe the child nor do they have the mental health skills to understand the significance of the child's symptoms displayed during the crisis. (This is situation is exacerbated with children under five years of age.)

- Medical Hubs: CSWs pointed out that screenings conducted at the medical Hubs were less likely to result in a positive assessment. CSWs also reported that some medical Hub staff members indicated they have experienced difficulties completing the MHST. Other DCFS managers, moreover, noted that MHST positive results vary across medical Hubs.

D. RECOMMENDATIONS

- Strengthen the checkpoint with existing cases to ensure that a MHST is administered. Consider formalizing the RTS' role with regards to checking for the completion of an MHST with existing cases during the course of case updates.

- Improve the process of filling out the MHST under difficult circumstances. Consider enhancing the training by adding additional information and strategies on how to fill out the MHST when working with children 0-5 and in crisis situations. The DCFS Training staff also recently provided MHST training to all medical Hub staff to improve the accuracy in the completion of the screening tool at the medical Hubs.

III. REFERRING CHILDREN WITH POSITIVE SCREENINGS FOR AN ASSESSMENT

A. Summary

The process of referring children with positive mental health screenings to full assessments is also strong. Strengths include a clear understanding of the referral packet requirements; formal referral procedures; MedsLite system to determine Medi-Cal eligibility; and the data-tracking system to facilitate referral flow.

The key challenges with referring children to assessments are two: gathering the appropriate consent for services in a timely fashion and establishing or maintaining Medi-Cal eligibility for certain children in the child welfare system.

B. What Worked Well?

Formal referral procedures.

- Each office has procedures ensuring that positive screenings for newly detained or non-detained children are referred to the SLS or MAT Coordinator for assessment. The procedures include personally handing over the file boxes containing case files directly to the clerk, SLS, or MAT Coordinator.

- All offices also use email or phone calls to inform the CSW that the assessment has been scheduled or to communicate any other issues with the file that must be cleared up before the case can be assessed. For each case, CSWs and ISWs are aware of the items needed to make a referral.

Clear Lines of Responsibility and Supportive Roles

- The CSW is responsible for tracking the case throughout the system and for completing the packet with the documentation needed for the assessment.

- However, most offices also reported that the MAT Coordinator or SLS actively assists the CSWs with completing the packet in order to expedite the file.

- In preparing the packets, the assistance of the MAT Coordinator and SLS is largely informal and depends on their proactive approach. The assistance is also dependent on the number of files and workload pressure of the MAT Coordinator and that person's specific role at each site.

Clear Understanding of Referral Packet Requirements

- There is a formal checklist of items that must be completed and must be in the referral packet before the case can move to the assessment stage.

- Elements of the packet include: ER investigative material, CSW findings, court documentation, TDM information, Hub report, benefits establishment (Medi-Cal), MHST and consent (release of information and consent for services).

- The trainings provided to staff and the post-training support included information about what a complete referral packet must contain.

The Data-Tracking System Facilitates the Flow of Referrals

- The MAT Coordinator and SLS use the data-tracking system to move the referral from the CSW to the assessment.

- SCSWs and other managers indicated SLS and MAT Coordinators are using the data-tracking system to track referrals before the file has been officially handed over.

- Cases might be returned to the CSW if there is a change in Medi-Cal status or consent, suggesting that when files are missing information, staff in other parts of the process flag the issue.

MedsLite accelerates the process of determining if a child is eligible for Medi-Cal.

- In the past, DCFS staff members relied on non-DCFS staff for printouts that confirmed Medi-Cal status. Determining Medi-Cal eligibility is essential in terms of accessing services. CSWs and ISWs rely on MedsLite to determine Medi-Cal eligibility. MedsLite allows users to view the Medi-Cal status of a child and print a confirmation page.

- Recently, MAT Coordinators and Service Linkage Specialists have been trained and authorized to access MedsLite to verify Medi-Cal eligibility.

- Staff members from all offices stated that DCFS staff members' ability to access MedsLite has substantially shortened the turnaround time to determine Medi-Cal eligibility.

C. What are the Challenges?

Obtaining consent for information and treatment is a complicated process

Obtaining consent for information and consent for services is a complicated process that can delay the completion of the referral packet.

Consent	Issues
Parent or legal guardian	Timing for consent is crucial because parents or guardians might not want to sign if they are emotionally stressed or upset, feel that mental illness is a stigma, or they are mistrustful of the department. Finding the parent or legal guardian to sign the consent form can be difficult. The parent or guardian might be unable to sign because the form may not be available in languages other than English.
Children twelve years or older	In some instances, CSWs will include consent from a child who is twelve years or older in order to move the referral process along. Consent granted by children twelve years or older is not always accepted by providers or DMH Co-located staff for assessment or service provision.
Courts	When the courts use standardized language on a minute order, it speeds up the completion of the case packet and referral, but the court's language on minute orders has not been standardized across the system. When minute orders do not use the correct language or are too specific, this can delay the referral process. In some cases, attorney orders are easier to obtain in the short term, but attorney orders are not always accepted by DMH or service providers.

Establishing and maintaining Medi-Cal benefits can also be a complicated process.

Three different situations emerged from focus groups and interviewee.

Situation 1: The child is not eligible for Medi-Cal.

Some children with positive screenings do not qualify for full-scope Medi-Cal. Although children who are not Medi-Cal eligible are not members of the Katie A. class, CSWs are in a situation where they need to conduct an assessment for children who have positive screenings. In some cases, a child might qualify for emergency Medi-Cal, but that type of Medi-Cal is not accepted by most service providers. Resources for these cases vary by SPA but are generally limited.

Situation 2: The child is enrolled in private insurance or HMO Medi-Cal

Children enrolled in private insurance programs or HMO Medi-Cal need to be dis-enrolled from their current medical provider and enrolled in full-scope Medi-Cal. The process of disenrollment can take more than a month if the parent or caregiver is hesitant to make the change.

When children have private insurance or HMO Medi-Cal, the CSW works with the caregiver and County representatives to dis-enroll the child and enroll the child in full-scope Medi-Cal. CSWs report that private insurance medical providers can be quite uncooperative. For instance, CSWs noted difficulties in obtaining information and records about children enrolled with private medical service providers.

When the child is not able to enroll in full-scope Medi-Cal and must remain under the current insurance provider, the CSW works with the medical providers to obtain mental health services for the child.

The issues associated with dis-enrollment cause delays.

Situation 3: The child is placed outside of Los Angeles County

Placing children outside the County reportedly occurs most often in cases where offices are located near the boundaries of Los Angeles County. When children are placed with a family or foster-care parents residing in a different county, the CSW coordinates the service provision with a provider that accepts Los Angeles County full-scope Medi-Cal. In such cases, it is the responsibility of the CSW to link the child to services.

However, out-of-county providers do not always accept certain types of Medi-Cal. The child must be enrolled in full-scope Medi-Cal offered by the county where the child is placed.

In these cases, the child tends sees a delay in services while they are transferred to a service provider outside of Los Angeles County.

Establishing these types of out-of-County Medi-Cal issues can also delay a case one to two months, if not longer.

D. RECOMMENDATIONS

- Improve the process of obtaining consent from various parties to decrease delays in starting the assessment.

- Strengthen the process of determining eligibility and obtaining Medi-Cal for those who are eligible.

- Accelerate the dis-enrollment process for children with private insurance or HMO Medi-Cal and for children placed outside of Los Angeles County.

IV. ASSESSING AND LINKING CHILDREN WITH POSITIVE MENTAL SCREENINGS

A. Summary

The Coordinated Service Action Team (CSAT) was viewed as a structure that has brought greater order, efficiency, and accountability to assessment and linkage services for newly detained cases (Track 1) and non-detained and existing cases (Tracks 2 and 3, respectively). CSWs underscored that CSAT is a structure that brings together staff with special skills, knowledge, resources and networks to ensure that children in Track 1 (MAT Program) or Tracks 2 and 3 (SLS and DMH Co-located) are appropriately and efficiently assessed and linked to services.

However, in contrast to screening and referral processes, staff members reported encountering a greater number of implementation challenges with assessment and linkage activities. The key challenges for assessing and linking children to services varied by track and Service Planning Area, and revolved around three issues: (a) availability of assessment slots and assessment capacity issues; (b) difficult deadlines, expectations, delays and costs; and (c) distancing, roles and partnerships.

B. What Worked Well?

A Strong Process for Newly Detained (Track 1) Children

- The MAT Coordinator is responsible for finding a MAT Provider with an open time slot for an assessment within a certain timeframe.
- The MAT provider is responsible for coordinating and facilitating the MAT assessment, which includes interviews, education information, caregiver information, placement information and concerns, and a Hub report.
- A Summary of Findings Report is created and submitted to the CSW for review and approval.
- After the Summary of Findings Report has been approved, the MAT provider, CSW, or MAT Coordinator focus on linking the child to services.
- DCFS and DMH collaborate in specific instances where there is a backlog of children waiting for a slot for a MAT assessment. DMH Co-located staff have helped perform a mental health assessment and provided mental health services while a MAT slot is identified.

A Strong Process for Non-Detained (Track 2) and Existing Cases (Track 3)

The SLS is responsible for working with the DMH Co-located staff within a specific timeframe to provide a mental health assessment, treatment, and/or service linkage to the DMH provider network.

If urgently needed service capacity is not available within the DMH provider network, the DMH Co-located staff will provide mental health services to the child while a provider is found to conduct a mental health assessment and/or to provide treatment.

C. What are the Challenges?

Track 1: Newly Detained and Specific SPAs

Availability of Assessment Slots and Assessment Capacity Issues:

- In some SPAs, as the providers began to ramp up their staffing to perform MAT assessments, the number of newly detained children needing assessments exceeded the amount of Multidisciplinary Assessment Team spaces available for assessments.
- In some instances, MAT providers responsible for coordinating assessments and linkage lacked the linguistic, cultural, or other capacities to conduct assessments.

Difficult Deadlines, Expectations, Delays and Costs:

- Even when MAT slots are available or MAT providers have the capacity to conduct the assessment, CSWs report that they regularly have to ask the court for extensions in order to comply with the requirements of the case.
- For instance, the court schedules a detention hearing 15 days after detainment. Follow-up reports are based on the court's timeframe.
- However, a medical Hub report has a timeframe of 30 days.
- The completion of the assessment—, which includes the medical Hub report—has a completion time frame of 30 to 45 days.
- Frustrations were expressed with the Summary of Findings Report, which is needed in order to conclude the MAT assessment. Completing this report is difficult for several reasons. For example, the CSW and caregiver must review and approve the Summary of Findings Report, but they often reject based on range of minor or major problems. CSWs can also reject the Summary of Findings Report if it does not contain any new

information or is lacking information that might be critical in deciding the course of action for a child.

- CSWs in different offices apparently apply different standards for accepting or rejecting the Summary of Findings Report. If the MAT Provider has to re-write the Summary of Findings, this adds to more costs to the process.

- Staff members from various offices also stated that the Summary of Findings Report rarely included the medical Hub report because it does not tend to arrive on time for MAT assessments.

Tracks 2 and 3: Non-Detained or Existing Cases

The use of SLS and DMH Co-located staff places greater distance between the CSWs and the mental service providers.

- CSWs generally characterized this situation as a mixed blessing or a paradox. On the one hand, CSWs recognize the positive aspects of having the SLS, DMH Co-located, and MAT Coordinators and MAT Providers specialize in screening, assessment, and linkages.

- On the other hand, the introduction of CSAT means that CSWs are not as active in creating and maintaining a direct connection to mental health service providers.

- At the same time, CSWs reported not having clear communication protocols to keep the CSW in the loop with the case during the assessment and linkage process.

DMH Co-located Staff Expanding Roles beyond Expertise, Skills, and Networks

- DMH Co-located staff (and mental health contract providers) indicated that in some cases when conducting mental health assessments and linkages, they routinely facilitate referrals and linkages beyond their field of expertise.

Not working as equal partners.

- In different offices across the SPAs, DMH Co-located staff expressed feeling that DCFS staff members treat them as people who work for DCFS rather than treating them as equal partners.

D. RECOMMENDATIONS

- Align the various deadlines for completing assessments.
- Reduce delays of reports from the medical Hubs.
- For Newly Detained Cases:
  - Consider establishing a system to redistribute MAT slots across SPAs.
  - Increase MAT provider capacity for conducting assessments in specific SPAs.
  - Strengthen the protocols (roles, expectations, processes) for completing the Summary of Findings Report.
  - Address the billing issues reported by MAT providers regarding assessments and service linkage.
- For Non-Detained and Existing Cases:
  - Clarify the role of DMH Co-located staff and mental health providers with regard to assessments and service linkage activities.
  - Address partnership issues between DCFS and DMH staff to support and foster a better collaborative relationship.

V. PROVIDING SERVICES TO CHILDREN WITH MENTAL HEALTH NEEDS

A. Summary

The successes and challenges with mental health service provision were the most difficult to gauge through this implementation evaluation study, primarily because the implementation experiences were so recent in two of the three SPAs. In addition, the Core Practice Model training curriculum, which focuses on the practice principles including Child/Family Teams, had not been completed or delivered to DCFS or DMH staff.

The evaluation nevertheless asked staff to share their views and experiences (limited as these may be) about the strengths, challenges, and recommendations regarding mental health service provision. All offices expressed confidence that Wraparound services provided mental health services in accordance with the practice principles specified in the Strategic Plan. CSWs and Intensive Social Workers (ISWs) reported that they regularly check in with Wraparound service providers regarding case files.

The key challenges with mental health service provision centered on mental health services delivered via a non-Wraparound approach. The key challenges revolved around the CSWs' understanding of their role in Child/Family Teams and the absence of formal, cross-agency teaming mechanisms; and the multiple constraints that mental health providers felt impinged on their ability to deliver mental health services in accordance with the practice principles in the Strategic Plan.

B. What Worked Well?

Wraparound Services Are Consistent with Core Principles

- Participants in the focus groups and the interviews felt that Wraparound services were consistently implementing the Strategic Plan's practice principles. When slots are available, Wraparound liaisons begin contact with children within a week of referral. Wraparound is able to provide services consistent with the core principles because it has been in existence longer, and staff know what these providers do and how they do it. This helps CSWs and others understand the referral process. Strong Wraparound liaisons have been instrumental in engaging in a dialogue with DMH Co-located staff members and the CSWs, which enhances communication concerning referred children.

- The Wraparound liaisons are consistently involved in the Team Decision Making (TDMs) and assessments. This allows CSWs and other staff members to build a relationship and create an understanding with Wraparound service team members. This relationship

assists the CSWs in gauging the quality of service as well as more accurately updating the status of children receiving services.

CSWs and ISWs regularly check in with service providers to update case files and to meet court requirements in cases of detention.

- CSWs are contacting service providers in a timely fashion to obtain information on children participating in mental health services. In most instances, service providers are able and willing to discuss a child and provide updates, within the boundaries of confidentiality.

- The reports contain information on the number of sessions a child has attended and if the child has reached certain milestones. Updates from the service provider are crucial for meeting court and file maintenance requirements.

C. What were the Challenges?

Case-carrying Children's Social Workers (CSWs)

Little Awareness of Practice Principles and Roles.

- CSWs were generally unaware that they should play a central role in creating Child/Family Teams. (This is understandable, of course, because the Core Practice Model training has not been provided.)

- However, a number of CSWs reported not being involved as a team member in a Child/Family along with the mental health service providers.

Weak Cross-Agency Teaming Structures

- CSWs indicated that most of the communication between them and mental health providers tends to revolve around court-mandated reports or file updates with existing or non-detained cases. They also indicated that in many cases, the reports do not contain qualitative information.

- They also cite confidentiality rules as a barrier to accessing qualitative information beyond what is court-mandated. Confidentiality issues occur. Distance between the CSW and the provider heightens that problem.

- Many times the information the CSW obtains is incomplete or inadequate to satisfy reporting requirements. CSWs monitoring of cases is largely driven by the need to report back to the court.

Children's Mental Health Providers

Substantial Budget Cutbacks to Mental Health Providers

- Agencies have experienced substantial budget cuts, and agencies have responded by cutting staff positions, adjusting job duties, and/or moving staff to different positions. The cutbacks affect their ability to match staff skills with children in need of mental health services. As cutbacks occur and staff turnover kicks in, linguistic and cultural capacity diminishes.

Training Needs

- Service providers spend a lot of time training staff members and bringing them up to speed, only to have those employees either leave the organization or change positions. Service providers noted that universities are not training workers in the now-required skills sets, which places greater responsibility on the service provider to train employees.

Lack of Buy-In at All Levels:

- Service providers indicated that it is difficult to implement the core principles of the Strategic Plan without the buy-in of staff at all levels, including administrative ones. Service providers stated that they have observed different rates of participation and varying magnitudes of understanding at all levels, including administrative ones. They feel they are not receiving clear messages about goals, clear instructions on how to conduct their work, and even billing requirements. Service providers believed that there needed to be more of a focus on buy-in by supervisors and Area Regional Administrators because the latter can impact the culture and the actions in an office.

D. RECOMMENDATIONS

- Increase awareness of CSW's role in Child/Family Teams and the Core Practice Model.
- Strengthen the mechanisms for cross-agency collaboration between the CSW and the service provider
- Address the structural challenges faced by the mental health provider particularly training issues, staff turnover, and other issues identified by mental health providers.

VI. CONCLUSION: NEXT STEPS

This evaluation project found that the screening and referral processes were the components most successfully implemented in this initial phase. By contrast, the assessment and service linkage processes encountered the greatest amount of challenges. Service provision also faced quite a few challenges, but the implementation of this component was too recent in two of the three SPAs to gauge its key strengths and challenges.

As the Department of Children and Family Services and Department of Mental Health consider how to address the recommendation contained in this report, a useful way of addressing these recommendations is by organizing them into three areas: practice protocols; training; and policy. (Some recommendations can fall into more than one category.)

Practice Protocols: Some of the recommendations may require modifying or formalizing roles and expectations. These decisions can be made by department leadership.

Component	Recommendations
Screening	• Further formalize the roles of staff who responsible for ensuring that in existing cases children are screened for mental health needs.
Referrals	• Improve the ways in which release of information and consent for mental health treatment are obtained.
Assessment and Linkage	• Reduce delays of reports from the medical Hubs. • Strengthen the protocols (roles, expectations, processes) for completing the Summary of Findings Report. • Address the billing issues reported by MAT providers regarding covering the full costs of assessments and service linkage. • Clarify the role of DMH Co-located staff and mental health providers with regard to assessments and service linkage activities. • Address partnership issues between DCFS and DMH staff to support and foster a better collaborative relationship.
Service Provision	• Strengthen the relationship between CSWs and mental health providers by reducing communication barriers and creating mechanisms to gauge

quality of services and outcomes.

Training: Some recommendations are probably best addressed as training issues.

Component	Recommendations
Screening	• Improve the process of filling out the mental health screening tool in specific contexts, namely for children 0-5, for crisis situations, and in the medical Hubs.
Referrals	• Improve the ways in which release of information and consent for mental health treatment are obtained.
Assessment and Linkage	• Reduce delays of reports from the medical Hubs. • Address partnership issues between DCFS and DMH staff to support and foster a better collaborative relationship.
Service Provision	• Increase the understanding of CSWs regarding their role in Child/Family Teams.

Policies: Other recommendations may require a change in formal policy at different levels.

Component	Recommendations
Screening	Minimize the problems of Medi-Cal enrollment and disenrollment, particularly for children with private insurance, HMO Medi-Cal, or placements outside Los Angeles County.
Referrals	• Improve the ways in which release of information and consent for mental health treatment are obtained.
Assessment and Linkage	• Align the various deadlines for completing assessments. • Consider establishing a system to redistribute MAT slots across SPAs.
Service Provision	• Address some of the structural conditions reported by the mental health providers, such as the issues of funding gaps.

VII. APPENDICES

A. Evaluation Research Approach and Methods

The implementation evaluation focused on the successes and challenges encountered during initial implementation of the Strategic Plan in order to provide recommendations on how to improve implementation in the remaining parts of the county. This research project used a formative evaluation approach, which seeks to understand the contextual factors that affect the implementation of a program or initiative. Contextual factors can include organizational dynamics, roles and processes, and funding, to name just a few components.

The evaluation project focused on the experiences of DCFS and DMH staff responsible for implementing two components of the Strategic Plan: the mental health screening and assessment and mental health service provision (Appendix 3). Data for this evaluation project came from 27 focus groups, seven each with case-carrying Children's Social Workers (CSWs), Coordinated Service Action Teams (CSATs), and Supervising Case Social Workers, and six with DMH Co-located staff. Additionally, 18 individual interviews were conducted with Regional Administrators, Area Regional Administrators, District Chiefs, and Program Heads. Additional information was gathered during a special meeting of the Children's Mental Health Providers Network.

The questionnaire (Appendix 4) for the focus groups and interviews was organized into four sections: screening, referral, assessment and service linkage, and service provision activities. Each section contained three anchoring questions: What is working well with the implementation? What challenges have been encountered during implementation? What recommendations do you have to improve the implementation? Each anchoring question had additional probing questions.

The information gathered was coded into themes according to the relevant section, anchoring question, and focus group or interview type. For example, information from the case-carrying Children's Social Workers across seven sites about the challenges with the screening process were brought together and coded by themes.

The strength of these qualitative research methods is that the researchers heard directly from those who are implementing the Strategic Plan objectives pertaining to mental health screenings and assessments and mental health service provision. However, the evaluation methods possessed a critical limitation: the information collected was primarily based self-reporting.

To strengthen the validity of the information, the evaluation team ran27 focus groups (27) and conducted 18 interviews. In most cases, seven focus groups were facilitated with the same group (for example one CSW group across seven sites).

The evaluation researchers sought to validate the data by applying two criteria. The first criterion was repetition: if two or more groups—or two or more people in the same group—mentioned the same strength, challenge, or recommendation within a particular process

(i.e., screening, referral, assessment and service linkage, or service provision), the item was turned into a theme.

A second criterion for creating a theme was whether an issue had a bearing on a system. If an issue was presented only once but it was relevant to a system, it was turned into a theme. An example of this is the MedsLite system. The introduction of the MedsLite system was mentioned once during the interviews, but this item has a major impact on the referral process because it accelerates the determination of Medi-Cal eligibility, which is critical in terms of moving a case to the assessment stage.

These two criteria (i.e., repetition and system impact) were also used to develop recommendations. The researchers developed recommendations by starting with recommendation explicitly offered by focus group participants and interviewees. Emphasis was placed on those recommendations that were presented several times and across sites. However, in cases where a pattern of challenges crystallized across several sites but no one presented a corresponding set of recommendations, the researchers developed the recommendations.

It is important to point out that this report's recommendations are not the same as solutions. The recommendations are framed as goals that will require identifying the specific strategies or solutions at a later point. Although the focus group participants and interviewees offered specific ideas and solutions to resolve particular problems, it was beyond the scope of this project and the expertise of the researchers to vouch for the validity or viability of the proposed solutions. Instead, the researchers captured the range of ideas presented as recommendations and can make these ideas available upon request as this process moves into the next stage of identifying concrete solutions to assist with the roll out of the Strategic Plan in the remaining SPAs.

B. Katie A. Strategic Plan Goals

The Katie A. Strategic Plan is comprised of six interlocking goals:

1. Mental Health Screening and Assessment – Ensure mental health screening and assessment for 100% of children formally and informally entering foster care, as well as those already receiving child welfare services.

2. Mental Health Service Delivery – Provide the most timely and individualized mental health services to children to promote stability of placements or prevent removals from home.

3. Funding of Services - The County is refocusing their energies and prioritizing strategies utilizing the Title IV-E funds, EPSDT dollars, and MHSA FSP slots to fund the mental health services needs for the Katie A. class members.

4. Training - The November 2006 Order from Judge Matz reiterated the Panel's concerns from their Fifth Report to the Court indicating that efforts to train staff fall short of the intended objectives because trainings do not impart the foundations of good practice—engaging families, effective teaming and coordination, thorough assessment of strengths and needs, individualized planning, and effective interventions. The Court directed the County to obtain feedback from DCFS and DMH workers to better inform needed enhancements to the training curriculum.

5. Caseload Reduction - Although caseload reduction is not a mandated component of the Katie A. Settlement Agreement or 2006 Court order, DCFS senior managers, in concurrence with the Katie A. Panel, view reduced caseloads as a vital objective necessary to execute the objectives of the Katie A. Settlement Agreement and subsequent orders.

6. Exit Criteria and Formal Monitoring Plan - The 2006 Order from Judge Matz tasked the County with developing measurable exit conditions and monitoring criteria, in order to demonstrate unequivocally that the County has fulfilled the provisions of paragraphs 6 and 7 of the Settlement Agreement.

C. KATIE A. STRATEGIC PLAN: MENTAL HEALTH SCREENING AND ASSESSMENT AND SERVICE PROVISION

The Katie A. Strategic Plan's Mental Health Screening and Assessment and Mental Health Service Delivery goals' implementation is designed in the following manner:

Mental Health Screening and Assessment

The goal of this component is to ensure the mental health screening and assessment of 100% of children formally and informally entering foster care, as well as those already receiving child welfare services. To achieve this goal, three tracks were established to screen and assess children in foster care.

Track One: Emergency response referrals resulting in detention

- All newly detained children receive a comprehensive mental health assessment and linkage to service through the Multidisciplinary Assessment Team (MAT) Program, within 45 days of being detained.

- MAT assessments focus on the following key areas: mental health; physical health; developmental milestones; hearing/language development; caregiver/family of origin; and educational and vocational needs.

- Medical evaluation is conducted at a medical Hub or by a community medical provider. The comprehensive evaluation must be performed within 72 hours of detention, if a high-risk case, and30 days for all others.

Track Two: Emergency response referrals resulting in a non-detained, open case (family maintenance or voluntary family reunification)

- All will receive mental health screening by the case-carrying Children's Social Worker.

- The Mental Health Screening Tool (MHST), developed by the California Institute for Mental Health (CIMH), will be used to administer the screening. The MHST was developed for non-clinicians, and it requires little formal training to use and can be administered quickly.

- If the screening is positive, link to appropriate services through DMH Specialized Foster Care Co-located Staff (if EPSDT eligible) or through a DCFS Service Linkage Specialist.

- Protocols for conducting the screening will be developed.

Track Three: All Existing/Open Cases

- The case-carrying CSW will complete the CIMH MHST when the next case plan update is due.

- Exceptions include children with a previously completed MHST; children already receiving mental health services; and children receiving D-rate placements.

- A subsequent screening is required upon identification of a behavioral indicator.

The infrastructure to support and expedite screening and assessment activities include:

Coordinated Services Action Team (CSAT)

- New administrative and teaming structure within each DCFS office to align and coordinate DCFS and DMH non-line staff to rapidly provide screenings and/or referrals and ensure service linkage.

- CSAT is comprised of DCFS, DMH, DPH, and DPSS staff (Team Decision Making staff, Multidisciplinary Assessment Team staff, Resource Utilization Management (RUM)/Resource Utilization Management Process (RMP) staff, D-Rate, Wrap, public health nurses, educational liaisons, Service Linkage Specialists, Youth Development Specialists, Permanency Partners Program (P3) staff, Adoption Safe Families Act staff, Specialized Foster Care staff, and Linkages co-located staff).

- Align and integrate siloed services/programs into CSAT—protocols delineating respective operational responsibilities for CSAT staff under development.

Team Decision Making (TDM)

- TDM is a meeting process teams up family, community partners, service providers, support networks, and facilitators to make decisions concerning a child's safety and placement, particularly in relation to a child's removal, re-placement, or return home.

- TDM facilitators are integrated into CSAT.

Resource Utilization Management Process (RMP)

- The focus is to transition children out of congregate care through a coordinated care approach to meet the needs of children currently in, or at risk of, placement in a RCL 6 – 14.

- Child and Adolescence Needs and Strengths (CANS) tool administered by DCFS RUM staff and DMH psychologists to determine the most appropriate placement/services.

- RUM staff and DMH psychologists are integrated into the TDM and CSAT structures.

Family Centered Services Referral Tracking System

- The referral form will allow some case-identifying and demographic information to be pre-populated and forwarded to CSAT for service linkage and follow-up.

- First phase would entail flagging DCFS referrals with special projects code, which would be uploaded regularly to DMH. Referrals would be matched against DMH billing codes to provide a service receipt dispositional report, which would not allow for case management but would provide the basics to track service provision.

- Second phase would be for DMH to build a case management application in which information could be entered, copied, and pasted back in CWS/CMS.

Mental Health Service Delivery

The goal is to provide the most timely and individualized mental health services to children to promote stability of placements or prevent removals from home.

To achieve this goal, practice principles were established requiring a team approach to deliver Intensive Home-Based Services that require (1) a strength-based approach for serving families; (2) a multiagency collaborative team approach; and (3) services that are responsive to cultural context and family characteristics.

Child and Family Teams (CFTs) operate with a facilitator, who ensures adherence to the practice principles, and a Parent Partner, former primary caretaker of children, who generally acts as an advocate and resource coordinator for the family.

CFTs are grounded in a Wraparound approach of doing "whatever it takes" to serve the families.

D. QUESTIONNAIRE

Katie A. Strategic Plan: Formative Evaluation: Questionnaire

I. **INTRODUCTION** [Approximately 5 min or less]

- Welcome and thank you for attending this focus group.
- My name is [ ] and I will be facilitating this focus group.
- This focus group is scheduled to last approximately 1 hour and 15 minutes.
- As you may know, the Katie A. Strategic Plan intends to provide [OPTIONAL: this could be on a flipchart]:
    - '... a single roadmap for the implementation of an integrated child welfare and mental health system, in fulfillment of the objectives identified in the Katie A. Settlement Agreement to be accomplished over a five-year period...' (Katie A. Implementation Plan Quarterly Updates, 9/30/09).
- SPAs 1, 6, and 7 were the first ones to begin implementing the Strategic Plan. The Plan will be rolled out across the remaining SPAs over the course of 2010.
- The purpose of this focus group is to learn from you about HOW the implementation of the Katie A. Strategic Plan is going at your site.
- Your experiences and insights are critical because what we learn from these focus groups will help shape how the implementation process is adjusted and shaped for the current and upcoming SPAs.
- To get a well-rounded perspective, we are conducting focus groups with CSWs, SCSWs, CSAT members, DMH Co-located Staff; and we are also conducting interviews with Regional Administrators, Assistant Regional Administrators, District Chiefs and Program Heads.
- IMPORTANTLY, we are not here to evaluate anyone's INDIVIDUAL performance. Rather, we are here to get a grounded understanding—based on your experiences—of how the implementation systems, processes, protocols, and roles are working.

II. GETTING STARTED [Approximately 5 min or less]

- Let me review three things in order to get us started with the focus group.
- FIRST, we want to record this conversation so that we can capture the nuances of what you say. The recording will stay with us, The INNOVA Group, until we complete this study (January 30, 2009).
- We will dispose of the digital recordings at that time. We will type the key points raised in this focus group, and omit any references to names.
- Can we have your permission to record?
- [FACILITATOR: Turn on the recorder, repeat the question, and begin recording from this point forward.]
- SECOND, the questionnaire will cover five areas [FACILITATOR: use a flip chart so that it is visually clear for participants. Use a similar as the hand out below]:
    - Identifying children and youth with mental health needs (i.e., screening and assessment).
    - referral to services;
    - service linkage, including responsiveness of other staff/providers in system;
    - service provision; and
    - an open-ended area for your comments.
- For each of these areas, we want to know:
    - what is working well, if anything;
    - what challenges you are experiencing, if any; and
    - what recommendations you have, if any, on how to improve things.
- THIRDLY, we are going to use the 'FISH DIAGRAM' to organize this conversation.
    - We will with the NEWLY DETAINED CASES and then the NON-DETAINED/EXISTING CASE.
    - So, let's begin by giving you 7-10 minutes to get your thoughts on paper (refer to the table).

III. FILLING OUT TABLES [Approximately 10 minutes/Ask them to 'pair up' to get energy flowing. Circulate tables and fish diagram.]

NEWLY DETAINED

	Working Well	Challenges	Recommendations
Identification			
Referral Process			
Service Linkage and Responsiveness			
Service Provision			

NON-DETAINED/EXISTING

	Working Well	Challenges	Recommendations
Identification			
Referral Process			
Service Linkage and Responsiveness			
Service Provision			

IV. FIRST AREA: IDENTIFYING CHILDREN AND YOUTH WITH MENTAL HEALTH NEEDS [approximately 15 minutes.]

A. NEWLY DETAINED CASE

1. What is working well with identifying children and youth in need of mental health services?
   a. Has the process changed from before? If so, how?
      i. Probe: Screening
      ii. Probe: Assessment
2. Are there challenges? If so, which ones?
3. What recommendations would you give on how to improve this process or area?

B. NON-DETAINED/EXISTING CASES

1. What is working well with identifying children and youth in need of mental health services?
   a. Has the process changed from before? If so, how?
      i. Probe: Screening
      ii. Probe: Assessment
2. Are there challenges? If so, which ones?
3. What recommendations would you give on how to improve this process or area?

V. SECOND AREA: REFERRAL PROCESS [approximately 15 minutes.]

A. NEWLY DETAINED

1. What is working well with the referral process for mental health services?
   a. Probe for the following (NOTE: Make sure to cover MAT, WRAP, and Intensive In-Home Services):
      i. Consent process?
      ii. Benefits establishment?
      iii. Referrals to MAT?
      iv. Referrals to Wraparound?
      v. Referrals to Intensive In-Home Services?
2. Are there challenges? If so, which ones?
   a. Probe:
      i. Consent?
      ii. Benefits establishment?
      iii. MAT?
      iv. Wraparound
      v. Intensive In-Home Based Services?
3. What recommendations would you give on how to improve this process or area?

B. NON-DETAINED/EXISTING CASES

1. What is working well with the referral process for mental health services?
   a. Probe for the following (NOTE: Make sure to cover MAT, WRAP, and Intensive In-Home Services):
      i. Consent process?
      ii. Benefits establishment?
      iii. Referrals to MAT?
      iv. Referrals to Wraparound?
      v. Referrals to Intensive In-Home Services?
2. Are there challenges? If so, which ones?
   a. Probe:
      i. Consent?
      ii. Benefits establishment?
      iii. MAT?
      iv. Wraparound?
      v. Intensive In-Home Based Services?
3. What recommendations would you give on how to improve this process or area?

VI. THIRD AREA: LINKAGE TO SERVICES [approximately 15 minutes.]

A. NEWLY DETAINED

1. What is working well with the linkage to services?
   a. How are service providers responding to the linkage?
   b. How much time is it taking to obtain mental health services?
   c. Probe: MAT coordinator?
2. Are there challenges? If so, which ones?
3. What recommendations would you give on how to improve this process or area?
   a. Probe: MAT coordinator?

B. NON-DETAINED/EXISTING CASES

1. What is working well with the linkage to services?
   a. How are service providers responding to the linkage?
   b. How much time is it taking to obtain mental health services?
   c. Probe: Service Linkage Specialist and DMH Co-located?
2. Are there challenges? If so, which ones?
3. What recommendations would you give on how to improve this process or area?
   a. Probe: Service Linkage Specialist and DMH Co-located?

VII. **FOURTH AREA: SERVICE PROVISION** [approximately 15 minutes.]

A. **NEWLY DETAINED/EXISTING CASES**
1. What is working well with the mental health services provided to children?
   a. How do you follow-up with mental health providers?
   b. How do you gauge the quality of the mental health services?
2. Are there challenges? If so, which ones?
3. What recommendations would you give on how to improve this process or area?

B. **NON-DETAINED/EXISTING CASES**
1. What is working well with the mental health services provided to children?
   a. How do you follow-up with mental health providers?
   b. How do you gauge the quality of the mental health services?
2. Are there challenges? If so, which ones?
3. What recommendations would you give on how to improve this process or area?

VIII.

IX. **FIFTH AREA: ADDITIONAL INFORMATION** [approximately 5-10 minutes.]

A. **TRAINING**
1. What worked well with the training?
2. How can it be enhanced? What would have been helpful?

B. Is there any additional information you would like to mention?

C. Have there been any unintended consequences?

D. Are there any new developments?

E. GLOSSARY OF TERMS

1. **ARA** – DCFS Assistant Regional Administrator
2. **CSAT** – Coordinated Service Action Team
3. **CSWs** – Children's Social Workers
4. **DCFS** – Los Angeles County Department of Children and Family Services
5. **DMH** – Los Angeles Department of Mental Health
6. **DMH Co-located Staff** – DMH Staff that are located in DCFS offices
7. **ER workers** – Emergency Response workers
8. **HIPAA** – Health Insurance Portability and Accountability Act of 1996
9. **HMO Medi-Cal** – Private Healthcare Providers who are contracted by Los Angeles County Medi-Cal.
10. **ISWs** – Intensive Social Workers
11. **MAT** – Multidisciplinary Assessment Team
12. **MAT Coordinator** - Staff members that coordinate the assessment for newly detained children.
13. **MAT Provider** – Contracted agencies that provide assessments and services for children in foster care.
14. **Medi-Cal** – Public Health Insurance program for low-income families.
15. **Medical Hub** – Contracted agencies that provide medical services for foster care children.
16. **MedsLite** – Computer software that allows user to identify the Medi-Cal status of children
17. **MHSA** – Mental Health Services Act
18. **MHST** – Mental Health Screening Tool
19. **RA** – DCFS Regional Administrator
20. **SCSWs** – Supervisor Case Social Worker
21. **SLS** – Service Linkage Specialist
22. **SPA** – Los Angeles County Service Planning Area
23. **TDM** – Team Decision Making
24. **Wraparound** – Los Angeles County initiative since 1998 that integrates multi-agency, community-based planning to support families so that they can safely and competently care for their children.

F. REFERENCE LIST OF FOCUS GROUPS AND INTERVIEWS

1. CSAT Team. Interviewed by Alexis Moreno. Focus Group, November 17, 2009. Los Angeles—Vermont Offices, CA.
2. CSAT Team. Interviewed by James Thing. Focus Group, November 19, 2009. Lancaster, CA.
3. CSAT Team. Interviewed by James Thing. Focus Group, November 17, 2009. Santa Fe Springs, CA.
4. CSAT Team. Interviewed by Samuel Monroy. Focus Group, November 19, 2009. Palmdale, CA.
5. CSAT Team. Interviewed by Samuel Monroy. Focus Group, November 18, 2009. Commerce, CA.
6. CSAT Team. Interviewed by Taffany Lim. Focus Group, November 17, 2009. Compton, CA.
7. CSAT Team. Interviewed by Taffany Lim. Focus Group, November 18, 2009. Los Angeles—Waterridge Offices, CA.
8. DCFS Assistant Regional Administrator. Interviewed by Alexis Moreno. Personal Interview, November 19, 2009.Lancaster, CA.
9. DCFS Assistant Regional Administrator. Interviewed by James Thing. Personal Interview, November 19, 2009.Lancaster, CA.
10. DCFS Assistant Regional Administrator. Interviewed by James Thing. Personal Interview, November 17, 2009. Santa Fe Springs, CA.
11. DCFS Assistant Regional Administrator. Interviewed by Rigoberto Rodriguez. Personal Interview, November 17, 2009. Compton, CA.
12. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, November 19, 2009. Palmdale, CA.
13. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, December 9, 2009. Compton, CA.
14. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Los Angeles—Vermont Office, CA.
15. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Los Angeles—Vermont Office, CA.
16. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Los Angeles – Vermont Office, CA.
17. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Commerce, CA.
18. DCFS Assistant Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Santa Fe Springs, CA.

19. DCFS CSW's. Interviewed by Alexis Moreno. Focus Group, November 17, 2009. Los Angeles–Vermont Office, CA.
20. DCFS CSW's. Interviewed by James Thing. Focus Group, November 19, 2009.Lancaster, CA.
21. DCFS CSW's. Interviewed by James Thing. Focus Group, November 17, 2009. Santa Fe Springs, CA.
22. DCFS CSW's. Interviewed by Rigoberto Rodriguez. Focus Group, November 17, 2009. Compton, CA.
23. DCFS CSW's. Interviewed by Samuel Monroy. Focus Group, November 18, 2009. Commerce, CA.
24. DCFS CSW's. Interviewed by Taffany Lim. Focus Group, November 18, 2009. Los Angeles – Waterridge Office, CA.
25. DCFS CSW's. Interviewed by Taffany Lim. Focus Group, November 19, 2009. Palmdale, CA.
26. DCFS Regional Administrator. Interviewed by Alexis Moreno. Personal Interview, November 17, 2009. Los Angeles – Vermont Office, CA.
27. DCFS Regional Administrator. Interviewed by Alexis Moreno. Personal Interview, November 19, 2009.Lancaster,CA.
28. DCFS Regional Administrator. Interviewed by James Thing. Personal Interview, November 17, 2009. Santa Fe Springs, CA.
29. DCFS Regional Administrator. Interviewed by Rigoberto Rodriguez. Personal Interview, November 17, 2009. Compton, CA.
30. DCFS Regional Administrator. Interviewed by Samuel Monroy. Personal Interview, December 17, 2009. Commerce, CA.
31. DCFS Regional Administrator. Interviewed by Taffany Lim. Personal Interview, November 19, 2009. Palmdale, CA.
32. DCFS SCSW's. Interviewed by Alexis Moreno. Focus Group, November 17, 2009. Los Angeles – Vermont Office, CA.
33. DCFS SCSW's. Interviewed by Alexis Moreno. Focus Group, November 19, 2009.Lancaster,CA.
34. DCFS SCSW's. Interviewed by James Thing. Focus Group, November 17, 2009. Santa Fe Springs, CA.
35. DCFS SCSW's. Interviewed by Samuel Monroy. Focus Group, November 18, 2009. Commerce, CA.
36. DCFS SCSW's. Interviewed by Samuel Monroy. Focus Group, November 19, 2009. Palmdale, CA.
37. DCFS SCSW's. Interviewed by Taffany Lim. Focus Group, November 17, 2009. Compton, CA.

38. DCFS SCSW's. Interviewed by Taffany Lim. Focus Group, November 18, 2009. Los Angeles – Waterridge Office, CA.

39. DMH Co-located Staff. Interviewed by Alexis Moreno. Focus Group, November 17, 2009. Los Angeles – Vermont Office, CA.

40. DMH Co-located Staff. Interviewed by Samuel Monroy. Focus Group, November 17, 2009. Santa Fe Springs, CA.

41. DMH Co-located Staff. Interviewed by Samuel Monroy. Focus Group, November 18, 2009. Commerce, CA.

42. DMH Co-located Staff. Interviewed by Taffany Lim. Focus Group, November 17, 2009. Compton, CA.

43. DMH Co-located Staff. Interviewed by Taffany Lim. Focus Group, November 18, 2009. Los Angeles – Waterridge Office, CA.

44. DMH Co-located Staff. Interviewed by Taffany Lim. Focus Group, November 19, 2009. Palmdale, CA.

45. DMH District Chief SPA 1. Interviewed by Rigoberto Rodriguez. Personal Interview, December 10, 2009.Lancaster, CA.

46. DMH District Chief SPA 6. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Los Angeles – Vermont Office, CA.

47. DMH District Chief SPA 7. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009, Santa Fe Springs, CA.

48. DMH Program Head SPA 1. Interviewed by Samuel Monroy. Personal Interview, November 19, 2009. Palmdale, CA.

49. DMH Program Head SPA 6. Interviewed by Taffany Lim. Personal Interview, November 18, 2009. Los Angeles – Waterridge Office, CA.

50. DMH Program Head SPA 7. Interviewed by Samuel Monroy. Personal Interview, November 17, 2009. Santa Fe Springs, CA.

Attachment II

COUNTY OF LOS ANGELES

MARVIN J. SOUTHARD, D.S.W.
Director

ROBIN KAY, Ph.D.
Chief Deputy Director

RODERICK SHANER, M.D.
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DEPARTMENT OF MENTAL HEALTH

http://dmh.lacounty.gov

550 SOUTH VERMONT AVENUE, LOS ANGELES, CALIFORNIA 90020

Reply To:
Fax:

June 15, 2009

Richard Saletta, LCSW
7950 Ridge Road
Newcastle, CA 95658

Dear Mr. Saletta:

Katie A. and the Provision of Wraparound and Related Services

We received a copy of the April 3, 2009 order appointing you Special Master in the Katie A. case. Accordingly, we are writing to provide information which may assist you, the State, and Plaintiffs in upcoming work and to offer the County's ongoing assistance as you deem appropriate and helpful.

As a county that provides wraparound and related services, and as a party to the Katie A. case, we seek to better understand how counties may structure programs to provide these services. To this end, we have enclosed a declaration the County recently filed in this case highlighting some critical operational questions related to county provision of wraparound and like services. An examination of this declaration should assist you and the other parties in this case to better understand the current informational/technical needs of this and other counties.

To further assist, we now propose answers to the questions posed in the earlier declaration. Accompanying each answer below, you and the other parties will find the legal and programmatic basis for each of our propositions.

In the future, we would like to provide additional information about county wraparound programs and to directly participate in discussions around this and related issues. Please do not hesitate to contact me through the information listed above to obtain whatever County assistance you deem appropriate in this regard.

County's Position on Paragraph 5(a)

In a variety of places in DMH Letter No. 08-07 ("DMH Letter"), the State Department of Mental Health ("Department") indicates that activities will be reimbursable if "Medi-Cal criteria are met." In Section II of the DMH Letter, the Department has defined Medi-Cal criteria to include the requirements that (A) the provider meet the standards for

participation, (B) the beneficiary is Medi-Cal eligible without restrictions, (C) the services are medically necessary, (D) the services are within the provider's legally defined scope of practice and (E) the services are appropriately supervised. Presumably, the requirement in the discussion of each service that Medi-Cal criteria must be met means that each of these requirements must be satisfied by the particular services in order for it to be directly paid by Medi-Cal. While it is easy to understand how the requirements at (B), (D) and (E) apply in the context of wraparound services, (but see discussion below on the accuracy of the requirements in (E)), it is less clear how the requirement that the provider meet the standards of participation, and the medical necessity criteria will be applied to individual services, particularly those that that do not strictly have to be done by a licensed person, such as team formation and the actions of the team facilitator.

The County's position with respect to the requirements on the provider in Section II.A, is that, so long as the entity which bills or is reimbursed for the service is duly enrolled in Medi-Cal, the requirement should be deemed to be satisfied. As the State is aware, among the purposes of the specialty mental health waiver was to allow the use of paraprofessional and other personnel in the provision of mental health care, without having to make them fit into the more rigid individual provider categories of classic Medi-Cal. Moreover, the requirements in (D) and (E) assure that the services are rendered by qualified and properly supervised personnel.

With respect to the medical necessity criteria (Section II.C) the County believes that it should be deemed to be satisfied for each of the team planning services outlined in Section V of the DMH Letter, so long as the individual which is the subject of team planning has an included diagnosis and one of the qualifying impairments. The services listed in Section V are necessary elements of the organized and coordinated provision of medically necessary clinical services. Although they themselves may not directly result in a reduction in impairment or deterioration, they are related to and in furtherance of those goals, and therefore should be independently recognized as medically necessary and billable. Indeed, Medi-Cal has long recognized that predicate or administrative actions, like agency staff meeting to discuss who should be a part of the weekly family meetings and assigning responsibility for contacting the proposed attendees to encourage their attendance are necessary components of care and has covered them. Accordingly the Department should affirm that medical necessity for such services exists where the services is related to or in furtherance of medically necessary clinical care.

County's Position on Paragraph 5(b)

We believe that the limitation of covered services to those under the supervision of a Licensed Professionals of the Healing Arts ("LPHA") is unduly restrictive and that

Marriage and Family Therapists ("MFTs"), waivered psychologists, and registered social workers should be able to provide care and supervision. Although the term is not defined in the regulations, an LPHA is generally understood not to include MFTs, registered clinical social workers or waivered psychologists. However, the regulation at 9 Cal. Code Regs. §1840.314(e)(1) which sets forth the qualifications of the individuals who may provide supervision for Medi-Cal covered mental health care, is not so limited. That regulation at subsection (e)(1)(D) specifically permits MFT's to act as care supervisors, and subsection (e)(1)(F) permits waivered/registered professionals to do so, so long as they are supervised in accordance with the laws and regulations governing their status. (See Business and Professions Code § 4996.21 related to supervision of registered clinical social workers) and § 2914(c) (related to psychologists). Allowing such individuals to provide supervision is consistent with the provisions of Welfare and Institutions Code § 5751.2, which expressly permits waivered/registered social workers and psychologists to provide services to Medi-Cal eligible recipients. (See also, DMH Letter 02-09 recognizing that MFTs, registered clinical social workers, and waivered psychologists may provide covered care). Finally, the Agreement between the Department and Mental Health Plans includes all the staff noted in this paragraph as being a part of the "approved category of staff" that may provide direction. Accordingly, the Department should recognize that all of professionals listed in Section 1840.314(e)(1) and similarly in the Agreement (Exhibit A, Attachment 1, Appendix C) can supervise Medi-Cal compensated wraparound services. To accomplish this, the Department should replace the phrase "Licensed Practitioner of the Healing Arts" with, "approved category of staff" which is used in MHP Agreement.

County's Position of Paragraph 5(c)

The only reference to "interagency and intra-agency consultations, coordination, and referrals" made in the DMH Letter is in Section 5.A.2, Team Formation. It is important that the State acknowledge that reimbursable interagency and intra-agency interactions may occur at any time during the Wraparound process. These contacts are important for assuring that mental health services are planned and delivered appropriately given the other conditions affecting the client. Similarly, it is important for other agencies to understand and consider on an ongoing basis the effects of their actions on the child's mental health so that adverse affects can be avoided or mitigated. Therefore all of the time spent on these contacts, throughout the clients' participation in Wraparound should be billable.

The Letter states that the activities conducted or facilitated by a mental health provider would be reimbursable. Because Wraparound is a Team approach, other members of the Wraparound mental health team may also be participants in these inter/intra-agency conferences. Their participation allows them directly to hear and interact from their perspective/role on client issues. This participation is important to the client's mental health treatment planning and execution. Except where the interchange with other

agencies may involve business or eligibility issues; we believe that the time of all mental health team members who have a legitimate reason to participate in an interagency conference should also be Medi-Cal reimbursable.

County's Position on Paragraph 5(d)

The County believes that the time spent by a mental health professional preparing documents (reports, letters, declarations, etc) which are filed with a court or governmental entity having authority over a client should be considered a billable and reimbursable mental health services so long as the documents:

(a) relate to medications for the client's mental health problem, or

(b) address the effect of the client's participation in a placement or program on his or her mental health problem.

For many of the children who participate in a wraparound program, the courts, not their parents, have the authority to make decisions about their medical care. For example, Cal. Welf. & Inst. Code § 369.5 provides that only a juvenile court officer may make decisions regarding the administration of psychotropic medications. Therefore, providing information to the court regarding the need for, or the termination or modification of psychotropic drugs is a necessary step in treating the client. It is analogous to the process of receiving informed consent for the administration of medication, which is expressly recognized in the regulations as a covered component of medication support services. (See 9 Cal. Code Regs. § 1810.225.) Accordingly, the Department should acknowledge that time spent preparing and presenting material to a court regarding mental health-related medications is both billable and reimbursable by Medi-Cal.

Further, it is well established that the mental condition of children with mental health problems are affected by the placements and programs in which the child participates. Environments or programs that are either too restrictive or insufficiently controlled can not only influence a child's behavior, but also impede or enhance the direct therapeutic services that the child is receiving from a mental health professional. For this reason, preparing documentation to a court, or governmental agency or contractor regarding the effect of a particular placement or program on the mental health of a client, as well as making appropriate recommendations, is an important part of assuring the efficacy of other covered mental health services. Because these services are related to assuring the effectiveness of the other clinical services described in the Client Care Coordination Plan, they should not have to be separately listed in the plan to be covered by it. The Department should also recognize these activities as billable and reimbursable mental health services.

County Position on Paragraph 5(e)

The County believes that the Department should issue an Information Notice which formally adopts the EPSDT Chart Documentation Manual, created by California Institute of Mental Health (CiMH), as official guidance on the acceptable standards for documenting EPSDT services, and hold harmless providers who follow such guidelines. However, because the current Manual is occasionally inconsistent with current law or policy, it should be reviewed and revised prior to its adoption. Moreover, the County believes that the Department should work with CiMH and the MHPs periodically to prepare updates which refine existing Manual information and address new programs and services, and formally to adopt such updates when they are issued. The first such update should refine existing Manual language and address documentation standards for wraparound services.

County Position on Paragraph 5(f)

In the DMH Letter, Section V.A.1 recognizes that the gathering of strength-based information, establishing a "strength-based and individualized service plan (mental health client plan)", and "strength focused conversation" are services reimbursable under Medi-Cal. Because this appears to conflict with 9 Cal. Code Regs. §1830.205 which identifies one of the required elements of Medical Necessity as impairments on which interventions are based but makes no mention of strength-based interventions, written clarification of the interplay between these two different treatment philosophies is necessary. Specifically, guidance is needed on the degree to which documentation must link strength-based goals and interventions to the Code required impairment-based goals and interventions. The County believes that the Department should find that it is billable and reimbursable to gather the information necessary to take a strength-based approach when doing an assessment, and that case planning and therapy time which utilizes a strength-based approach, relying on strength-based information, is billable and reimbursable, so long as the effect of such approach is to limit deterioration of the client's mental condition or remediate an impairment.

County Position on Paragraph 5(g)

The County believes that the time spent reviewing information which is provided with a service referral should be considered billable as part of the client assessment. As the DMH Letter recognized in Section III.A, assessment services include "analysis of the beneficiary's clinical history [and] analysis of relevant cultural issues and history." (See also 9 Cal. Code Regs. § 1810.204.) The materials which are provided with the service referral provide significant information about the client's past experiences, including information relating to the past provision on mental health services, prior behaviors, and significant life events. Knowledge of these experiences is critical in determining the etiology of disorders, and in gaining insight into a client's behaviors. Also helpful is

information about successful (as well as unsuccessful) strategies for dealing with the client's problems. All of this information assists the therapist who is conducting an assessment or crafting a Client Care Coordination Plan in preparing a better assessment/client plan, even though the material provided with the referral may be more broad-ranging than the information generally reviewed during an assessment. Accordingly, the Department should recognize that time spent reviewing these materials is essential for formulating a quality plan of care, and acknowledge that it is directly billable to Medi-Cal as part of the assessment service.

County Position on Paragraph 5(h)

To the extent that documentation indicates that a contact included more than just making an appointment, the County believes that the DMH Letter should be construed to allow providers directly to bill for activities such as explaining the Child and Family Team (CFT) process, and inviting significant support persons, such as an aunt, to participate. Often, as my declaration suggests, the participation of such individuals facilitates the client's own participation. In addition, the mental health system expects that service providers will contact and include relevant collaterals to better facilitate the progress or stability of a client. Moreover, recognizing such services as distinctly billable, would be consistent with the definition of covered "collateral" services in the regulation at 9 Cal. Code Regs. § 1810.206. While that definition focuses on achieving goals in the client's care plan, its recognition that contacts with significant support persons can "assist in better utilization of specialty mental health services by the beneficiary" applies equally well to the team formation period. Accordingly, the time communicating with these individuals during the team formation period, as well as during the assessment and plan development period, should be considered directly billable and reimbursable.

County Position on Paragraph 5(i)

The County believes that the discussion in Section V.C of a service plan refers to the Client Plan (in Los Angeles known as the Client Care Coordination Plan) that is required by Section B of Exhibit A, Attachment 1, Appendix C of the MHP Agreement between the County and the Department. The County is pleased that the DMH Letter recognized that covered services may be provided prior to the completion of that Plan as the documented behaviors and/or symptoms of the client often necessitate initiation of direct services before a comprehensive assessment and detailed Client Care Coordination Plan can be developed. The County asks that the Department expressly confirm in an Information Notice or similar document that, at a minimum, the mental health services listed in the second paragraph of V.C. may be reimbursed, when provided before the Client Care Coordination Plan is completed, so long as the services are consistent with the Plan finally developed.

County Position on Paragraphs 5(j&m)

The County's positions on Section III.C. (Personal Care) and Section V.C. (Plan Implementation/Tracking) of the DMH Letter have been grouped together because they require similar actions by the Department. In Section III.C of the DMH Letter, the Department notes that Personal Care Activities are not rehabilitation services and are not Medi-Cal reimbursable. However, Section 1905(a)(24) of the Social Security Act, provides federal Medicaid coverage for personal care services, so long as they are provided outside of a healthcare institution and not rendered by a family member. Personal care services have been incorporated as a benefit into Medi-Cal for categorically needy individuals (see 22 Cal. Code Regs. § 51350). Covered services include bathing, grooming, dressing, feeding and certain domestic services, as well as shopping and meal preparation services. (22 Cal. Code Regs. § 51183.) Therefore, although personal care services are not paid by the MHP, it is incorrect to suggest that they are not covered Medi-Cal services.

Supporting this position, the Department in section V.C indicates that other wraparound activities may be reimbursable under fee-for-service Medi-Cal. The County believes that these additional components of wraparound services should be considered reimbursable under fee-for-service Medi-Cal even though they are related to the client's mental illness: medical transportation, when provided in accordance with the regulation at 22 Cal. Code Regs. § 51323, pharmacy pursuant to 22 Cal. Code Regs. § 51313 et seq. and laboratory services pursuant to 22 Cal. Code Regs. § 51311. The County believes that the Department should issue an Information Notice to provide guidance to providers on how to receive Medi-Cal reimbursement through the regular Medi-Cal fee for service system, when such care is medically necessary.

County's Position on Paragraph 5(k)

The County believes that preparation of a discharge summary by the treating mental health professional within a reasonable time after service termination is always a Medi-Cal billable and reimbursable activity for clients in a wraparound program. To be covered, the discharge plan must be a concise, clinically-oriented description of the client's mental health at the time he or she was released from care, including vulnerabilities, strengths and appropriate follow up activities. Preparation of a discharge summary is required by the MHP Agreement between the Department and the County where "appropriate." (See Exhibit A, Attachment 1, Appendix C, p.41.) Such a document is always appropriate in the wraparound context because it provides the primary means of communicating with future caregivers, and other entities or agencies involved with the client's status on discharge. As the Department recognized in covering transition care, giving the client the tools and information he or she will require

in the future is a necessary component of covered clinical care. For this reason, time spent preparing a qualified discharge summary should be considered a billable mental health service.

County Position on Paragraph 5(l)

The County believes that the limitation on targeted case management services to those which can be specifically linked to the child's mental health related needs in DMH Letter Section III.F is incorrect and inconsistent with State law. A child's access to appropriate housing and nutrition can and does impact a child's mental condition. Nevertheless, the limitation in the letter could be construed to preclude the client from receiving case management help with housing or food, as those needs exist irrespective of mental illness. However, according to the regulation at 22 Cal. Code Regs. § 51351, targeted case management includes assistance with issues related to physical needs, such as food and clothing, and to housing and the physical environment. Limiting persons with mental health problems to a narrower range of targeted case management services undercuts the purpose of the program. The purpose of targeted case management is to provide extra assistance to certain fragile or high risk individuals who need referral and linkage assistance. The scope of the linkage and referrals is supposed to be based on a comprehensive plan created after a thorough assessment of the individual client's overall needs, not just to those needs that relate to the reason for which they have been deemed high risk. For example, persons on probation often receive referrals to health care providers, although health issues have nothing to do with why they are on probation. (See, 22 Cal Code Regs. § 51351(a) and (b).) Accordingly, it is inappropriate automatically to exclude certain types of referrals and linkage services for children with mental health problems simply because they do not directly address the client's mental health needs.

In other communications, the Department has suggested that linkages for housing and food are not covered targeted case management because it is the child's caregiver, and not the child, who is linked. Such a position ignores the obvious fact that decisions about food and housing cannot be made by children or even unemancipated young adults; caregivers are legally responsible for those decisions and the youth lack legal capacity to make them for themselves (e.g. they cannot sign a legally binding rental agreement). Under these circumstances, targeted case management must go through the caregiver if the child is to be served. Therefore, the Department must recognize that targeted case management services which link a covered child's caregiver to housing and food resources which will directly benefit the child are covered and billable Medi-Cal services.

County Position on Paragraph 5(n)

The County believes that Section III.E of the DMH Letter is too limited. It should be

expanded beyond the current provision stating, "Instructions for use as given to the parent by the provider to assist the parent in the appropriate response to the child's questioning of the need to take the medication..." explicitly to include in the scope of covered medication support services, instruction to parents or other caregivers on the proper method of administering mental health related medications and on how to monitor the child for potential side effects, as well as other aspects of the medication. As the Department is aware, parents or caregivers play a more active and important role in the behavior of children than they do with adults. Accordingly, it is critical that they, as well as the child, understand how to administer medication and know what the possible side effects can be. The regulation at 9 Cal. Code Regs. §1810.225 clearly provides both that instruction on the use and risks of the psychotropic medication and contacts with parents or caregivers are covered. The Department therefore must recognize that this regulation, read in light of the needs of children, clearly covers education to parents or other caregivers on all aspects of their child's medications, and is not limited to education on the need for the drugs.

Sincerely,

Olivia Celis, LCSW, MPI.
Deputy Director

Attachment